



University Medical Center of Southern Nevada
Authorization to Release Protected Health Information

Patient Name: Birthdate:
Street Address:
City: State: Zip Code:
Social Security #: (optional) Phone #:
Medical Record #: Account #: Mail Call for pickup

I authorize the disclosure of the above named individual's Protected Health Information (PHI) and request:

Name:
Address:

to release the requested information to:

Name:
Address:

The purpose for this requested information is: (Note: There is a \$0.60 per page photocopy fee)
Healthcare provider Personal use Attorney Insurance
Other, specify:

Date(s) of services requested:

The following information is requested:

- PHI pertinent for continuing healthcare or personal health records. Includes: Face Sheet, Emergency Record, H&P, Consult Report, Operative Report, Discharge Summary, Lab & Radiology Reports, EKG, EEG, Other Diagnostic Test Reports, Discharge Instructions
Anesthesia records
Autopsy report
Billing records
Conditions/Consent of Admission
Consent forms
Images / xrays / scans
Immunization records
Medication records
Nurses notes
Occupational Therapy Notes
Photographs
Physical Therapy Notes
Physician Orders
Physician Progress Notes
Speech Therapy Notes
Other, specify:

I acknowledge, and hereby consent to such, that the released information may contain alcohol or drug abuse, psychiatric, HIV or AIDS, sexually transmitted disease, or genetic testing content. (Initials)

This authorization will expire on the following date or event:

I understand that:

- 1. Authorizing this release of information is voluntary and I may refuse to sign this authorization.
2. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
4. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations.
5. I may receive a copy of this authorization.

Signature of Patient or Patient's Legal Representative Today's Date

Print Name of Legal Representative (if applicable) Relationship to Patient (if not the Patient)

Note: Guardians and Durable Power of Attorney designees should include a copy of the applicable paperwork